INJURY INFORMATION SHEET

Patient Name: _____ Birthdate: _____ Date: _____

Body part for visit today: _____ ☐ Right ☐ Left Referred By: _____

REASON FOR VISIT

Date of Injury (if applicable): _____

PLEASE EXPLAIN: _____

_____

IMPORTANT INFORMATION (PLEASE READ and SIGN)

* *I consent to examination, treatment and procedures which may be performed during office visits including emergency treatment considered necessary by the physician and/or his designated providers.*
* *I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.*
* *I understand that I am financially responsible for all charges whether or not paid by my insurance.* ***If no insurance payment after 90 days the balance becomes my responsibility.***

PATIENT OR GUARDIAN SIGNATURE: _____ DATE: _____

This information must be completed in order for us to bill for services. If it is not complete, the patient will be responsible for full payment at the time they are treated.

Do you want PICSM to bill a third party liability insurance? ☐ NO ☐ YES; if yes, fill out below

WORKER'S COMPENSATION

EMPLOYER AT TIME OF INJURY: _____ Phone #: _____

Please explain how accident/injury occurred?

_____

_____

DATE OF INJURY: _____ LAST WORKED DATE: _____

WORK COMP INSURANCE CARRIER: _____

WORK COMP CARRIER ADDRESS: _____
STREET ADDRESS CITY STATE ZIP

CLAIMS EXAMINER: _____ PHONE #: _____

CLAIM #: _____ FAX #: (if available) _____

AUTO ACCIDENT/THIRD PARTY LIABILITY INSURANCE

POLICY HOLDER: _____

CLAIM #: _____ ACCIDENT DATE: _____

INSURANCE AGENCY: _____ PHONE #: _____

AGENT: _____ FAX # (if available) _____

ADDRESS: _____
STREET ADDRESS CITY STATE ZIP